SUPREME COURT, U. S.

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MICHAEL RODAK, JR., CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1973

No. 73-1381

ATKINSON-DAUKSCH AGENCIES, INC.,
Plaintiff-Petitioner,

v.

JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY,
Defendant-Respondent.

PETITION FOR WRIT OF CERTIORARI

TO THE UNITED STATES COURT OF APPEALS, SIXTH CIRCUIT

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PETITION FOR WRIT OF CERTIORARI

TO THE UNITED STATES COURT OF APPEALS, SIXTH CIRCUIT

Plaintiff-Petitioner, Atkinson-Dauksch Agencies, Inc., hereby petitions the Court for a Writ of Certiorari to the United States Court of Appeals, Sixth Circuit, on the basis of the facts, arguments, and authorities set forth herein.

OPINIONS BELOW

The unreported decision of the United States Circuit Court, issued December 13, 1973.

The unreported decision of the United States District Court for the Southern District of Ohio, Eastern Division, issued January 2, 1973.

JURISDICTIONAL GROUNDS

Date of judgment sought to be reviewed

The judgment of the United States Circuit Court of Appeals, for the Sixth Circuit was rendered December 13, 1973. This motion is being filed within the ninety (90) day period required by Statute.

Statutory provisions conferring jurisdiction on the Supreme Court of the United States

28 U.S.C. 1254 (1). Court of appeals, certiorari; appeal; certified questions.

"Cases in the courts of appeals may be reviewed by the Supreme Court by the following methods:

(1) By writ of certiorari granted upon the petition of any party to any civil or criminal case, before or after rendition of judgment or decree;"

Basis for Federal Jurisdiction

This action was originally filed in the Common Pleas Court of Franklin County and was removed by Respondent to the United States District Court on the grounds of diversity.

QUESTIONS PRESENTED FOR REVIEW

(1) Does a provision in a life insurance application reading:

> "If the contract of insurance does not take effect as provided in such Conditional Receipt it shall take effect as of the Date of Issue of the policy but only upon delivery to and receipt by the Applicant of the policy and payment of the premium thereon, and *only if* at the time of such delivery and payment each person proposed for insurance in Parts A and B of this application, including the *proposed Insured,* is living *and has not consulted, been exam-*

ined, or been treated by a physician or practitioner since the latest Part B pertaining to such person was completed."

create a condition precedent preventing formation of a contract if the applicant for insurance does have medical attention and/or hospitalization between the application and the delivery of the policy.

(2) Where an insurance company is aware of a pre-existing health condition which creates an additional risk of early death and where such insurance company charges a premium of 237½% of the normal premium, can such insurance company take advantage of said provision in paragraph one above.

(3) Should a Motion for Summary Judgment be sustained and said decision affirmed by the United States Circuit Court of Appeals where there was medical testimony that the insured was in good health at the time of the delivery of the policy and where the statutory provisions of the State of Ohio indicate a legislative intent that such questions be resolved by presentation to a Jury.

STATUTORY PROVISIONS INVOLVED

There are no direct statutory provisions governing this problem. However, certain statutes are applicable by analogy. These are set forth in Ohio Revised Code Section 3911.06 and Ohio Revised Code Section 3911.07 herein.

STATEMENT OF THE CASE

John Hancock Mutual Life Insurance Company issued a policy on the life of Robert O. Miller, President of Atkinson-Dauksch Agencies, Inc., on October 14, 1968.

Atkinson-Dauksch Agencies, Inc., was, and is a large agency specializing in writing casualty insurance and surety bonds, primarily for contractors. Not being specialists in life insurance, Atkinson-Dauksch purchased

the policy through the William B. Hoyer Agency, one of the largest and oldest agents of John Hancock.

John Hancock had learned in 1965 that Miller had hypertension, and its medical department knew that hypertension is a forerunner of heart disease. This knowledge was obtained by John Hancock in 1965 when the Hoyer Agency made an inquiry to determine if John Hancock would write a policy on Miller's life. No policy was issued at that time, but in September, 1968, further inquiries were made of John Hancock in connection with the sale by the Hoyer Agency of three policies on the lives of the Atkinson-Dauksch executives. Further medical examination of Miller was had by John Hancock, and information was obtained from Miller's doctor, confirming the 1965 hypertension condition. In view of this medical problem, John Hancock determined that it would sell a policy on Miller's life only on a rated basis of 237.5% of the normal premium for a man Miller's age.

The Director of Underwriting of John Hancock reported to the Hoyer Agency:

> "Of course, I am sure you will appreciate that Mr. Miller should have a fairly *high rate at best.*" (Emphasis added)

Between the application, the John Hancock examination, and the decision to issue the policy on the rated basis, Miller attended a meeting at The Greenbrier, became ill, and was seen in the Greenbrier Clinic where his condition was diagnosed as hiatus hernia and upset stomach, but as a precaution he was referred to Clifton Forge Hospital, where he stayed three days and his heart was evaluated. The diagnosis at Clifton Forge was hiatus hernia and marked pyloral spasm. Miller's heart condition was thoroughly evaluated, and Dr. Ballou found that he had not suffered the heart attack, although he did have coronary arterial disease, which was a concomitant of the hypertension condition of which John Hancock

had knowledge. Miller was allowed to leave in three days, returned to Columbus by auto, appeared at his office the following Monday, where the policy was delivered, and saw his own doctor at the suggestion of the Clifton Forge doctor. His own doctor said he was in good health and normal at that time. He died two days later. At his final attack, his own doctor was so sure his heart was good that he prescribed a tranquilizer and hot water bottle.

REASONS RELIED ON FOR ALLOWANCE OF THE WRIT

(1) Specific reliance is placed on United States Supreme Court Rule 19 1 (b).

The decision of the Court of Appeals is in conflict with other United States Courts of Appeals, and is repugnant to the statutory law of the State of Ohio.

There is no clear Ohio Supreme Court decision, and, therefore, the question is a federal question. However, as we will point out later, certain statutes in Ohio evidence a clear intent to allow questions of the type presented here to be presented to a Jury.

Furthermore, the Ohio cases cited in the Court of Appeals opinion do not support its decision, and, in fact, as will be pointed out herein, support our contention that the Petitioner is entitled to a Jury trial.

The United States Court of Appeals decision which conflicts with the decision of the Court below is *Major Oil Corp. v. Equitable Life Assurance Soc. of U.S.*, 457 F 2d 596 (1972), and was decided March 29, 1972, by the Tenth Circuit Court of Appeals. A corporation had made application for a $250,000.00 life insurance policy on one of its principal officers. The insured had a great drinking problem, which he concealed in his application. However, other officers of the Plaintiff had advised the insurance agent of this drinking problem, and the insur-

ance agent and company had made other inquiry and learned of the drinking problem. Between the time of the application and the delivery of the policy the prospective insured was hospitalized and he complained about chest pains which he had been experiencing both at the hospital and for several months prior thereto.

The District Court directed a verdict in favor of the Plaintiff against the insurance company. The Court of Appeals affirmed the District Court, in *spite of the false answers in* the insured's application on the basis that the *Defendant insurance company had acquired some knowledge of* the insured's drinking problem, and, therefore, was put on notice and should have pursued the problem further. (Emphasis added)

In addition, the policy in the *Major* case contained a "good health clause" and, in considering this clause, the Court of Appeals said as follows at page *605*:

> "[4] Equitable also claims that there was such a change in Brimhall's physical condition between the date of the application and the date of the policy was delivered as to preclude Major from recovery on the policy, and as a corollary of this argument it is said that Brimhall was not 'in good health' on the date the policy was delivered and therefore the policy never took effect. Such is based primarily on the fact that Brimhall returned to Shadel Hospital after the date of his application for further treatment for his alcoholism at which time he also made complaint about chest pains. However, had Equitable pursued the MIB information to its logical conclusion it presumably would have availed itself of *all* the information at Shadel Hospital, which would have included, for example, the cardiology tests. And in any event, the cardiology tests were essentially negative in nature. Under all the circumstances we find no merit in this particular argument." [Emphasis added by the Court]

It certainly seems anomalous that the policy owner recovered in the *Major Oil* case where the insured made false statements in his application and was not in good health at the time of delivery of the policy, in addition to having been hospitalized, whereas, in the instant case, there is no doubt that the answers given by Mr. Miller in his application were true. Furthermore, the insurance company in the *Major Oil* case acquired some knowledge of the insured's drinking problem, while in the instant case John Hancock had acquired knowledge of Miller's hypertension and potentional heart problem in 1965.

We, therefore, feel the decision of the Tenth Circuit in the *Major Oil* case represents a more sound analysis of the problem in life insurance cases than the decision by the Courts below.

Speaking of the question of whether seeing a doctor avoids the policy, the author states in *Appelman on Insurance*, Section 155, p. 257:

> "It is the belief of this writer, that, despite the the strong language of many of these decisions, the courts will adopt the same construction as toward the 'delivery in sound health' rule and apply the exclusion only to serious disorders. Illinois has confined it to consultation or treatment for diseases which arose subsequent to the application."

One of the leading recent decisions by a State Supreme Court is the case of *Lynch v. Metropolitan Life*, 427 Pa. 418, 235 A 2d 406, which held for Plaintiff even though he was being treated for cancer when the policy was delivered. He did not know that he had cancer.

The policy was *rated.*

In its opinion, the Court said at pages *409 and 410*:

> "However, the evidence as to whether Lynch when he made the statements, *knew of their falsity or made them in bad faith falls short of* the stan-

dard of proof upon which the entry of a judgment n.o.v. can be predicated." [Emphasis added]

. . . "Insofar as the record indicates, Lynch at least prior to the time when he executed the amendment to the application, *did not know* that the difficulty in the testicle and the radiating pains in his chest, leg and back arose from the onset of a cancerous condition." [Emphasis added]

. . . "On the record before us, Lynch was *unaware* of the presence of any malignant condition in his body and of the relationship between such condition and the necessity for the removal of his testicle."

. . . "*It is natural to wonder why, if the operative procedure did not alert a doctor to the possibility of an existent serious condition, Lynch should be held to knowledge of the existence of such condition.*" [Emphasis added]

. . . "Whether *Lynch* had *knowledge* of the falsity of his statements and whether he acted in bad faith were *questions clearly for resolution by a jury* and not by the court below as a matter of law. In refusing to enter judgment n.o.v. for this reason the court below acted properly." [Emphasis added]

Other cases requiring knowledge by the insured that he has a serious medical condition before a policy can be avoided are: *Shafer v. John Hancock,* 410 Pa. 394, 398, 189 A 2d 234 (1963); *Marshall v. Metropolitan Life,* 405 Ill. 90, 90 N.E. 2d 194; *Madsen v. Metropolitan Life Ins. Co.,* 90 R.I. 176, 156 A 2d 203; *Harte v. United Benefit Life,* 56 Cal. Rep. 889, 424 P 2d 329 (1967) and *New York Life Ins. Co. v. Hesselring,* 236 Iowa 412, 19 N.W. 2d 191 (1945).

Robert Miller, the Insured in the instant case, had no knowledge that he had a heart condition.

(2) The Ohio Statutes

Revised Code Sections 3911.03 through 3911.07 are designed for the protection of the policyholders.

Revised Code Section 3911.06 reads:

"*3911.06. False answer.* (GC § 9391)

No answer to any interrogatory made by an applicant in his application for a policy shall bar the right to recover upon any policy issued thereon, or be used in evidence at any trial to recover upon such policy, *unless it is clearly proved that such answer is willfully false, that it was fraudulently made, that it is material, and that it induced the company to issue the policy, that but for such answer the policy would not have been issued, and that the agent or company had no knowledge of the falsity* or fraud of such answer." [Emphasis added]

Thus, had Mr. Miller been hospitalized *before* signing the application, and lied about it, the Plaintiff would have had more protection with an outright lie in the application because Defendant would still have to prove *clearly*:

1. The answer was wilfully false.
2. It was fraudulently made.
3. It was material.
4. It induced the company to issue the policy.
5. Except for the answer the policy would not have been issued.
6. The company's agent had no knowledge of the falsity or fraud of such answer.

Therefore, if the Courts below are correct, an insured who is hospitalized or treated between application and delivery of the policy, not *knowing* he had any serious condition, has no rights whatsoever, whereas a person who lies on his application still has the protection listed above.

This is indeed an anomalous situation, and cannot be the law.

Revised Code 3911.07 reads:

3911.07. Defenses limited (GC § 9392)

> "After having received three annual premiums on a policy issued on the life of any person in this state, all companies are estopped from defending upon any ground *other than fraud* against any claim arising upon such policy by reason of errors, omissions, or misstatements of the insured in an application made by him on which the policy was issued, except as to age." [Emphasis added]

Therefore, it is clear that the Ohio Legislature has required proof of fraud before allowing an insurance company to avoid a policy which has been issued. The District Court obviously failed to find any evidence of fraud and decided this case solely on the basis that no contract had been formed. Had Atkinson-Dauksch and Miller attempted to defraud John Hancock, Atkinson-Dauksch would at least have been entitled to a Jury trial on the issue of fraud. However, having been completely honest in the policy applications and in furnishing all required information, the Plaintiff-Petitioner has been denied a Jury trial, which the Ohio Statutes require.

(3) The Ohio Court Decisions.

The Court of Appeals below referred to the cases of *Metropolitan Life Ins. Co. v. Howle,* 62 O.S. 204 and *Metropolitan Life Ins. Co. v. Howle,* 68 O.S. 614. However, these cases do not support the Court's decision, nor do they deal with the questions involved herein.

The case of *Metropolitan Life Ins. Co. v. Howle,* 62 O.S. 204 was decided in 1900 and involved a "sound health" clause. The Supreme Court reversed a verdict for the Plaintiff, but ordered a new trial under different instructions. Therefore, this case would support our argument that we are entitled to a Jury trial on the issues involved herein.

The case of *Metropolitan Life Ins. Co. v. Howle,* 68 O.S. 614 involves the same parties, and the Supreme

Court of Ohio again reversed a judgment for the Plaintiff and again ordered a new trial.

Therefore, if these cases say anything about the law of Ohio as it applies to this case before the Court, they say that Plaintiff-Petitioner, Atkinson-Dauksch, is entitled to have the issues herein presented to a Jury.

SUMMARY

The "fine print" clause appended to the policy application should not be used to avoid the contract into which John Hancock entered. John Hancock had a voluminous file of correspondence and medical information about Robert Miller when it entered into the contract of insurance with Petitioner. John Hancock knew the risk it was taking by virtue of the fact that the premium was rated more than double the normal premium. Having chosen to gamble, John Hancock then decided to withdraw from its gamble, and the lower Courts have allowed Respondent to withdraw from its contract. As we have pointed out above, this clause is not in favor with other Federal Court decisions, and is against the majority of the State Courts which have spoken on this subject.

The correct position is best expressed in the opinion by the Court in *Hungate v. N.Y. Life Ins. Co.*, 267 Ill. App. 257 (1932), where the Court held in stating that a clause similar to the clause involved here was void as against public policy:

> "To so construe the provision in question would render it very unreasonable. The mere fact that an applicant consulted a physician about the most trivial ailment would be sufficient to prevent the policy from going into effect unless the insurer was advised of the fact. The applicant might pay the premium for several years thinking she had insurance but when she died the beneficiary would find that the contract never became effective. Even an incontest-

able clause would not apply if a policy never became a valid and binding contract. *Such a construction would be abhorrent to reason and justice.*" [Emphasis added]

The strict construction given this clause by the Courts below is abhorrent to reason and justice, and the Courts below should be reversed, and the Court should order that this case be presented to a Jury for determination of all the issues involved herein. The judgments of the Courts below should be reversed and this case should be remanded for a Jury trial on the issues involved herein.

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By: ----------
JACK R. ALTON

COLLIS GUNDY LANE,
Attorneys for Petitioner,
ATKINSON-DAUKSCH AGENCIES, INC.

AFFIDAVIT OF SERVICE

STATE OF OHIO)
FRANKLIN COUNTY) ss.

The undersigned, Jack R. Alton, Attorney for Petitioner, Atkinson-Dauksch Agencies, Inc., states that he has on the _____ day of _____, 1974, served by mail three printed copies of the foregoing Petition for Certiorari to the United States Court of Appeals, Sixth Circuit, on Mr. James O. Seymour, of Vorys, Sater, Seymour & Pease, 52 East Gay Street, Columbus, Ohio, 43215, Attorney for Respondent, John Hancock Mutual Life Insurance Company, being all parties required to be served.

_____

JACK R. ALTON

Sworn and subscribed to before me this _____ day of _____, 1974.

_____

Notary Public

APPENDIX A. OPINIONS BELOW AND ORDERS OF COURTS BELOW

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1. Atkinson-Dauksch Agencies, Inc. v. John Hancock Mutual Life Insurance Company, The unreported decision of the United States Circuit Court, issued December 13, 1973.

No. 73-1247

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

ATKINSON-DAUKSCH AGENCIES, INC.,
Plaintiff-Appellant,

v.

JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY,
Defendant-Appellee.

Appeal from the United States District Court for the Southern District of Ohio.

Decided and Filed December 13, 1973.

Before: EDWARDS and CELEBREZZE, Circuit Judges, and KRUPANSKY,* District Judge.

PER CURIAM. This is an action wherein plaintiff insurance agency as beneficiary seeks recovery of $200,000.00, the face value of a life insurance policy purportedly issued by the defendant on the life of its president, Robert O. Miller.

Finding no disputed issues of material fact the district court granted defendant's motion for summary judgment from which plaintiff appealed.

In substance the record reflects that on September 24, 1968, plaintiff's president, Robert O. Miller, delivered a duly executed application for a $200,000.00 life insur-

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* The Honorable Robert B. Krupansky, United States District Judge for the Northern District of Ohio, sitting by designation.

ance policy on his life payable upon his demise to the Atkinson-Dauksch Agencies, Inc., the plaintiff herein.

Conspicuous immediately above the signatures of Miller and plaintiff's agent was the following language:

A. The foregoing statements and answers are complete, true and correctly recorded, and with all Parts B of this application shall form the basis for and be a part of any contract of insurance.

B. If an advance payment is made with this Part A, and if the total amount of all insurance now in force plus the amount applied for in this and all other applications now pending on the life of the proposed Insured in this Company, does not exceed either $250,000 life insurance or $100,000 accidental death benefit, the contract of insurance shall take effect as provided in and subject to the terms and conditions of Conditional Receipt Form 156-CR-67 bearing the same date and number of this Part A. If the contract of insurance does not take effect as provided in such Conditional Receipt it shall take effect as of the Date of Issue of the policy but only upon delivery to and receipt by the Applicant of the policy and payment of the premium thereon, and only if at the time of such delivery and payment each person proposed for insurance in Parts A and B of this application, including the proposed Insured, is living and has not consulted, been examined, or been treated by a physician or practitioner since the latest Part B pertaining to such person was completed.

C. No agent or medical examiner is authorized to make or discharge contracts or waive or change any of the conditions or provisions of any application, policy or receipt, or to accept risks or pass upon in-

surability. Notice to or knowledge of any agent or medical examiner, whenever given, is not notice to or knowledge of the Company.

On October 5, 1968, while attending a convention of insurance agents at the Greenbrier Hotel, White Sulphur Springs in West Virginia, Miller experienced indigestion pains and consulted Dr. Brody for examination and treatment. Miller was admitted to the Chesapeake & Ohio Hospital in Clifton Forge, Virginia, on October 6, 1968, upon the request of Dr. Brody. He was examined and treated at the hospital by Dr. Charles Ballou who found no indication of myocardial infarction from a number of electrocardiograms performed under his supervision at the hospital. He was discharged on October 9, 1968, with a diagnosis of a small, sliding hiatus hernia and directed to immediately consult his own physician upon returning to his home in Columbus. It should be noted that Miller had a history of high blood pressure dating to at least 1964, which fact had been disclosed to defendant. Miller consulted his personal physician, Dr. George Clouse upon returning to Columbus who examined him on October 14, 1968. Dr. Clouse arrived at no negative findings. On October 15, 1968, Miller notified Dr. Clouse of recurring epigastric pain. Tranquilizers were prescribed. On October 16, 1968, Miller again experienced epigastic discomfort and expired that evening. Cause of death was listed as myocardial infarction due to coronary artery and hypertensive heart disease.

The defendant had written the policy of insurance here in question on October 10, 1968. It was delivered to Miller personally on October 14, 1968, however, neither Miller nor any representative of plaintiff company notified defendant or its representative of Miller's physical

condition or continuous medical consultation and treatment which commenced on October 5, 1968.

Defendant refused payment on the policy and tendered the return of the first premium payment which had been deposited with plaintiff's application. Disclaimer is predicated upon Part B of the application, that is, plaintiff's failure to notify defendant of Miller's medical consultation and treatment during the interim between the filing of the application for insurance and delivery of the policy.

The issue to be here decided is not one of fraud or misrepresentation, but one of contract law presented by an agreement between sophisticated parties.

It is conceded that Miller consulted and received medical treatment during the period defined by the policy, in fact, he was consulting with his physician at the period of time the policy was delivered. It is further conceded that defendant had not been made aware of the medical consultation and treatment.

The basic law be to applied in this case is Ohio law. It appears to be stated in *Metropolitan Life Ins. Co. v. Howle,* 62 Ohio St. 204, 56 N.E. 908 (1900); *Metropolitan Life Ins. Co. v. Howle,* 68 Ohio St. 614, 68 N.E. 4 (1903); and *New York Life Ins. Co. v. Wertheimer,* 272 F. 730 (N.D. Ohio 1920). While these cases arise out of somewhat different facts than our instant case, they seem to support the result reached by the District Judge.

Appellant urges the adoption of the pronouncements of the Tenth Circuit in *Major Oil Corporation v. Equitable Life Assurance Soc. of U.S.,* 457 F. 2d 596 (10th Cir. 1972), which exhibits a strong policy against forfeitures

as opposed to this Court's enforcement in *Subar v. New York Life Ins. Co.*, 60 F. 2d 239 (6th Cir. 1932), of a similar contract clause to the one in dispute in this case.

We decline to reconsider *Subar* in the context of this case where the claimed insured was himself president of an insurance agency and familiar with insurance law and practice, and where the intervening health problem and medical treatment were neither insignificant nor totally unrelated to claimed insured's heart problem.

Accordingly, the judgment of the district court granting defendant's motion for summary judgment is affirmed.

2. The unreported decision of the United States District Court for the Southern District of Ohio, Eastern Division, issued January 2, 1973.

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF OHIO EASTERN DIVISION

ATKINSON-DAUKSCH AGENCIES, INC.,
Plaintiff

vs.

JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY,
Defendant

OPINION AND ORDER

This matter is before the Court upon the defendant's motion for summary judgment under the provisions of Rule 56, F. R. Civ. P. This action was originally filed in the common pleas court. Removal was effectuated by the defendant pursuant to 28 U.S.C. §1441. Jurisdiction exists by virtue of the diverse citizenship of the parties, 28 U.S.C. §1332. The plaintiff, Atkinson-Dauksch Agencies, Inc., is incorporated in Ohio and has its principal place of business in Columbus, Ohio. The defendant, John Hancock Mutual Life Insurance Company, is a Massachusetts corporation having its principal place of business in Boston, Massachusetts. Venue lies in this court according to the provisions of 28 U.S.C. §1391. The complaint in this action seeks recovery of the face value of a certain life insurance policy allegedly issued by the defendant on the life of Robert O. Miller. The plaintiff is the alleged beneficiary of the insurance policy. The policy is for the amount of $200,000.00.

In ruling upon the motion the Court shall consider the pleadings, the briefs, the stipulations of fact, the depositions and the other documents presently in the record.

Summary judgment is appropriate only where there are no disputed issues of material fact and where the moving party is entitled to judgment as a matter of law. *Bailey* v. *American Tobacco Co.*, 462 F. 2d 160 (6th Cir. 1972); *Rogers* v. *Peabody Coal Co.*, 342 F. 2d 749 (6th Cir. 1965); *United States* v. *Diebold*, 369 U.S. 654 (1962); *Poller* v. *Columbia Broadcasting System, Inc.*, 368 U.S. 464 (1962). In ruling upon a motion for summary judgment the Court must construe the evidence in the light most favorable to the party opposing the motion. *Bohn Aluminum & Brass Corp.* v. *Storm King Corp.*, 303 F 2d 425 (6th Cir. 1962).

In accordance with the preceding elemental legal aphorisms the Court has considered the record and finds the following uncontroverted facts to exist. Robert O. Miller was formerly the president of the plaintiff corporation. The plaintiff sought to procure insurance on the life of Miller. On September 24, 1968 the plaintiff caused to be executed Part A of an application for life insurance with the defendant. Miller, as the proposed insured, executed Part B of the same application for insurance on September 23, 1968. Parts A and B of the application, before the Court as stipulated Exhibit A, bear Miller's signature. Part A bears the plaintiff's name as applicant and is signed by the plaintiff's agent. Parts A and B of the application for life insurance were delivered to the defendant on September 24, 1968.

Part A of the application includes the following provisions which conspicuously appear immediately above the signatures of Miller and the plaintiff's agent:

> A. The foregoing statements and answers are complete, true and correctly recorded, and with all Parts B of this application shall form the basis for and be a part of any contract of insurance.

B. If an advance payment is made with this Part A, and if the total amount of all insurance now in force plus the amount applied for in this and all other applications now pending on the life of the proposed Insured in this Company, does not exceed either $250,000 life insurance or $100,000 accidental death benefit, the contract of insurance shall take effect as provided in and subject to the terms and conditions of Conditional Receipt Form 156-CR-67 bearing the same date and number as this Part A. If the contract of insurance does not take effect as provided in such Conditional Receipt it shall take effect as of the Date of Issue of the policy but only upon delivery to and receipt by the Applicant of the policy and payment of the premium thereon, and only if at the time of such delivery and payment each person proposed for insurance in Parts A and B of this application, including the proposed Insured, is living and and has not consulted, been examined, or been treated by a physician or practitioner since the latest Part B pertaining to such person was completed.

C. No agent or medical examiner is authorized to make or discharge contracts or waive or change any of the conditions or provisions of any application, policy or receipt, or to accept risks or pass upon insurability. Notice to or knowledge of any agent or medical examiner, whenever given, is not notice to or knowledge of the Company.

Miller, accompanied by his wife, made a business trip to West Virginia in the first week of October of 1968. The Millers obtained a hotel room in White Sulphur Springs, West Virgina. After experiencing indigestion pains, Miller called a physician on October 5, 1968. Dr. Arnold Brody of White Sulphur Springs examined Miller

on October 5, 1968 and preliminarily diagnosed the existence of a diaphrogmatic hiatus hernia.

Brody treated Miller at the Greenbrier Hotel Clinic on October 5, 1968. An electrocardiogram was performed. Miller was admitted to the Chesapeake and Ohio Hospital, Clifton Forge, Virginia, on October 6, 1968 at Dr. Brody's request. At the hospital Dr. Charles Ballou examined Miller. A number of electrocardiograms were taken at the hospital and an upper gastrointestinal x-ray revealed the presence of a small, sliding hiatus hernia. Ballou found no evidence indicating that Miller had suffered myocardial infarction. Miller received demarol and intravenous injections at the hospital where he remained until being discharged on October 9, 1968.

The Millers returned to Columbus. On October 10, 1968 the defendant issued its policy of life insurance on Miller (stipulation Exhibit C). The policy was delivered to Miller, as president of the plaintiff, on October 14, 1968. The plaintiff paid the first quarter-annual premium of $5313.12 on October 14, 1968. Robert O. Miller died on October 16, 1968. Neither Miller nor the plaintiff informed the defendant of the medical treatment Miller had received immediately prior to his death.

The plaintiff furnished the defendant written proof of Miller's death on December 5, 1968. The defendant refused to pay the face value of the policy and, after the plaintiff filed this action, deposited $5313.12 plus interest with the registry of this court.

The defendant's basic position is that because Miller received medical treatment by physicians *after* the application was filed but *before* the policy was issued, the policy never legally came into existence. The defendant argues that the insured had an affirmative duty to dis-

close the new medical treatments and that he failed to do so. Secondly, the defendant relies upon the expressed language of the application that the policy would not become effective if Miller was examined or treated by a physician after the filing of Part B of the application.

The defendant's first argument may have validity under such cases as *Cohen, Friedlander & M. Co.* v. *Massachusetts M. L. I. Co.*, 166 F.2d 63 (6th Cir. 1948), *cert. denied*, 334 U.S. 820 and *Stipcich* v. *Insurance Co.*, 277 U.S. 311 (1928). The Court, however, agrees with the defendant's second argument that the expressed language of the application precluded the insurance policy from taking effect.

Under paragraph 16 of the insurance policy (see page 6 of stipulated Exhibit C) the entire contract between the plaintiff and the defendant consisted of the policy and the written application. Part A of the application[1], which was signed by Miller and the plaintiff's agent, expressedly provides that the contract of insurance shall take effect only if the proposed insured has not ". . . consulted, been examined, or treated by a physician or practitioner since the latest Part B pertaining to such person was completed." Miller completed the only Part B filed on September 23, 1968. He thereafter was examined and treated by no fewer than two medical doctors. Miller was admitted to a hospital for approximately three days where he was under constant medical supervision. The policy was not delivered to Miller until October 14, 1968. He was discharged from the hospital on October 9, 1968. Therefore, under the expressed contractual agreement between the defendant, Miller and

[1] According to the first sentence of Clause B in the application the policy could have taken effect as of the date of the filing of Part A if an advance payment was made with the filing of Part A. These terms do not apply to this action since no advance premium payment was made.

the plaintiff, the policy of insurance on Miller's life could not come into effect.

This action is controlled by *Subar* v. *New York Life Ins. Co.*, 60 F.2d 239 (6th Cir. 1932); *see also, New York Life Ins. Co.* v. *Gist*, 63 F.2d 732 (9th Cir. 1933), *cert denied*, 290 U. S. 651. In *Subar* a provision in a life insurance application, that is very similar to the one at bar, was held to have become part of the contract for insurance and thus precluded the life insurance policy from taking effect. The *Subar* court reasoned that:

> . . . A contract of insurance, as has been frequently held, rests upon and is controlled by the same principles of law applicable to other contracts, and the parties may stipulate and agree that it shall be effective at a given time, or upon the happening of a designated event, or shall not be effective at all if there occurs a specified intervening event. Bowen v. Prudential Insurance Co., 178 Mich. 63, 144 N.W. 543, 51 L.R.A. (N.S.) 587; Gallop v. Royal Neighbors, 167 Mo. App. 85, 150 S.W. 1118; New York Life Insurance Co. v. Griffith (C.C.A.) 35 F. (2d) 945. . . . *0 F.2d 240.

The plaintiff maintains that there is an additional factual issue to be determined that would warrant the denial of summary judgment. The plaintiff argues that the defendant is implying fraud on the part of Miller and that therefore Miller's intent in failing to disclose the medical treatment is of controlling import and that, of course, intent is a jury question. This argument completely misses the mark. The defendant has not alleged fraud on anyone's part. The defendant has merely stated that Miller's receipt of medical treatment after the filing of the application constitutes a contingency whose occurrence, by the expressed language of the application, precludes the policy from taking effect. The Court finds

particularly relevant the following iteration in the *Subar* case:

> . . . The point to be decided is accordingly not one of fraud or misrepresentation, but of contract law where the parties agreed that the insurance should not take effect upon the delivery of the policy and the payment of the premium if the insured consulted a physician after his medical examination. We know of no rule of law which renders such a provision ineffective. Cf. New York Life Ins. Co. v. Conrad, 47 F. (2d) 885 (6 C.C.A.). . . . 60 F. 2d 240.

Plaintiff has cited to the Court no Ohio authority that would require a result contrary to that reached in *Subar*. Nor, indeed, was the medical treatment received by Miller of the trivial or casual variety but rather was of sufficient seriousness to warrant hospitalization for three days. *See, Combs* v. *Equitable Life Insurance Co. of Iowa*, 34 F. Supp. 1002 (W.D. Va. 1940). The Court notes also that none of the parties to this insurance contract was an uneducated layman, but all were professional business individuals who must be held to have understood the plain import of the language in the application for insurance.

From the foregoing it is the determination of the Court that the insurance policy upon Miller's life never came into effect. There are no issues of material fact to be decided and the defendant must prevail as a matter of law.

WHEREUPON, it is the determination of the Court that the defendant's motion for summary judgment is meritorious and it is therefore GRANTED.

This action is hereby DISMISSED.

JOSEPH P. KENNEDY
United States District Judge

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IN THE

Supreme Court Of The United States

OCTOBER TERM, 1973

No. 73-1381

ATKINSON-DAUKSCH AGENCIES, INC.,
Plaintiff-Petitioner,

v.

JOHN HANCOCK MUTUAL LIFE INSURANCE
Defendant-Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS, SIXTH CIRCUIT
BRIEF FOR RESPONDENT IN OPPOSITION

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ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS, SIXTH CIRCUIT
BRIEF FOR RESPONDENT IN OPPOSITION

STATEMENT OF THE CASE

There are no disputed questions of fact in this case. Most of the facts were stipulated by counsel. Atkinson-Dauksch Agencies, Inc., plaintiff, made an application to John Hancock Mutual Life Insurance Company, defendant, on September 24, 1968 for insurance in the amount of Two Hundred Thousand Dollars ($200,000) on the life of plaintiff's president, Robert O. Miller. No part of any premium was paid to the defendant at the time the application was made. The contractual provision is correctly set forth in plaintiff's petition herein and provides that the policy shall take effect on delivery

and payment of the premium and only if at the time of such delivery and payment the proposed insured has not consulted, been examined or been treated by a physician or practitioner since the application was completed.

It was further stipulated that Robert Miller was examined and treated by a physician twice on either October 5 or October 6, 1968 and that he was treated by another physician several times on each of the days October 6, October 7, October 8 and October 9 and was confined to a hospital from October 6 at 2:40 P.M. to October 9. It was further stipulated that neither Robert O. Miller nor plaintiff told defendant on or before October 14, 1968 any of these facts respecting treatment and confinement and that at the time of the delivery of the policy on October 14, 1968 defendant did not know any of those facts.

The depositions and answers to interrogatories which were filed in this case comprise the rest of the record. They show that in 1965 plaintiff inquired of defendant as to the possibility of getting insurance on the life of Robert Miller. The statement of his attending physician, Dr. Clouse, showed that at that time Miller had a history of high blood pressure running as high as 180/100. The inquiry was not pursued and no application for insurance was made in 1965 and no insurance policy was issued.

In 1968, when the inquiry was renewed, Dr. Clouse submitted a statement to defendant wherein he stated that under medication Miller's blood pressure had been reduced so that the three readings in January, March and May of 1968 were all 140/90. Dr. Clouse further stated in said communication that Mr. Miller's present condition of health was "excellent."

Defendant indicated that it would consider insurance but that it would have to be written at a substandard rate because of the history of hypertension. Thereupon the application for the insurance was made by plaintiff to defendant.

On October 4, 1968 Mr. Miller went to an insurance convention in White Sulphur Springs. In the middle of the night (October 5-6) after he had arrived at the convention, while in his room at The Greenbrier, he had severe pains in his stomach and Dr. Brody, the house physician, was called. He spent about an hour with Mr. Miller and the next morning had an electrocardiogram taken in the facilities at the hotel. The electrocardiogram made Dr. Brody feel that Mr. Miller should be hospitalized and he was sent to the Chesapeake & Ohio Hospital at Clifton Forge, Virginia, which is about 30 miles away from White Sulphur Springs. Miller arrived at the hospital at 2:40 P.M. on October 6 and remained there until sometime on October 9, 1968 in the coronary unit of the hospital.

Dr. Ballou, who was in charge of the hospital, saw Miller three or four times a day and had three electrocardiograms taken on successive days. The electrocardiogram taken on October 8 showed for the first time an inversion of the T wave, which made Dr. Ballou feel that coronary insufficiency had developed and that Miller was possibly in danger of an impending infarction. Dr. Ballou testified about what he told Miller.

> "It was explained to him that he had a hiatus hernia which we have talked about, and that he also had coronary insufficiency, which had caused his pain, and also he had a spasm of his stomach which had also possibly caused his pain. But, in view of the electrocardiogram changes, we felt that he needed to be immediately hospitalized at home to go under

his doctor's care, and we advised him to continue his anticoagulant therapy so that his doctor could pick this up just where we had left off."

On October 9, 1968 Miller was taken back to Columbus. He didn't go to his doctor until October 14, 1968. On October 14, the policy of insurance was delivered to Miller as president of plaintiff. Miller did not tell John Hancock anything about his treatment or hospitalization described above. Within one and one-half hours after the policy was delivered, Miller went to see his doctor, Dr. Clouse, and told Dr. Clouse about the treatment and hospitalization described above.

Miller died on October 16, 1968 and Dr. Clouse executed a death certificate which is in the record in which he stated

"Immediate cause of death myocardial infarction.

"Approximate interval between onset and death 1½ hr.

"Due to coronary artery disease

"Approximate interval between onset and death 10 days."

Plaintiff, in its petition for writ of certiorari, states three questions presented for review.

ARGUMENT ON QUESTION 1

The first question relates to the validity of the provision that the insurance shall only take effect if the proposed insured has not consulted, been examined or been treated by a physician since the application was completed. The law on this question is so well established that there is no need for this Court to review it.

Subar v. New York Life Ins. Co., 60 F 2d 239 (1932) CC 6. *Natcchio v. New York Life Ins. Co.*, 200 F 2d 770

(1952) CC 3. *New York Life Ins. Co. v. Gist*, 63 F 2d 732 (1933) CC 9. *Hurt v. New York Life Ins. Co.*, 51 F 2d 936 (1931) CC 10. Certiorari denied 285 US 541.

All of these cases considered the validity of the contractual provision. All of these cases held the provision to be valid.

In *Girouard v. John Hancock Mutual Life Ins. Co.*, 98 RI 1, 199 Atl 2 307 (1964), the Supreme Court of Rhode Island, in coming to the same conclusion, stated, at page 309, concerning the federal authorities:

> "In addition the Circuit Courts of Appeal in the Second, Third, Sixth, Eighth and Tenth Circuits have reached like conclusions as did the Court in the Ninth Circuit in New York Life Insurance Company v. Gist.'

Plaintiff has cited no cases in which it was held that this provision was not valid.

ARGUMENT ON QUESTION 2

The second question which plaintiff says is presented by this case is whether the insurance company can take advantage of the contractual provision here involved when the company is aware of a pre-existing health condition which creates additional risk of early death and where the insurance company charged a substandard preium higher than normal. So far as we know, no one has ever advanced this argument before. If it were sustained, it would discourage the writing of substandard insurance. There is no reason for the courts to frown on substandard insurance. Mr. Miller had a history of hypertension, which was controlled by medication, and his doctor certified that his physical condition was excellent. The company, like everyone else, knew that a con-

dition of hypertension, even when controlled, tends to reduce the length of life expectancy. Everyone also knows that many policies are issued on substandard risks. Why should an insurer be less entitled to know of intervening medical treatment and hospitalization with respect to a substandard applicant than with respect to a normal applicant? It seems that the converse of this is true.

Plaintiff in this case was a large insurance agency and Mr. Miller was obviously sophisticated in the field of insurance. Plaintiff had a choice: By paying the premium at the time the application was made, plaintiff could have imposed on the insurance company the risk of any intervening medical treatment being required before the policy was delivered and the premium paid. Or. plaintiff, by chosing not to pay the premium until delivery, could itself assume the risk of intervening medical treatment being required. There is no reason why such a choice should not be made by an applicant for insurance. Plaintiff chose not to pay the premium at the time the application was made and consequently plaintiff bore the risk of the policy not becoming effective by reason of intervening medical treatment. This answers question 2 presented by the plaintiff.

ARGUMENT ON QUESTION 3

Plaintiff states as question 3 whether medical testimony that the insured was in good health at the time of delivery prevents a summary judgment and refers to certain Ohio statutes. With respect to the condition of health of the plaintiff at the time of the delivery of the policy, the death certificate of Dr. Clouse showing that the coronary artery disease arose 10 days before date of death, i.e. on October 6, 1968, is a complete answer.

The Ohio statutes quoted on pages 9 and 10 of plaintiff's petition show on their face that they deal only with errors, omissions and misstatements contained in an application. These statutes are not applicable to the present case because no claim is made by the defendant that any misstatements were contained in the application. This is not a case involving a claim of fraud. This is a case which deals with a contractual provision.

Judge Kinneary of the District Court disposed of this argument in his opinion as follows:

> "The defendant has not alleged fraud on anyone's part. Defendant has merely stated that Miller's receipt of medical treatment after the filing of the application constitutes a contingency whose occurrence, by the expressed language of the application, precludes the policy from taking effect." Citing Subar v. N. Y. Life Ins. Co. (supra).

The Circuit Court of Appeals toward the end of its opinion states:

> "The issue to be here decided is not one of fraud or misrepresentation but one of contract law by agreement between sophisticated parties."

DISCUSSION OF CASES CITED BY PLAINTIFF

Plaintiff cites two Ohio cases—*Metropolitan Life Ins. Co. v. Howle*, 62 OS 204, and *Metropolitan Life Ins. Co. v. Howle*, 68 OS 614, asserting that they require that the case be submitted to a jury. Both of these cases involve contractual provisions that the policy was not to go into effect unless on the date of delivery the applicant was alive and in sound health. The court in those cases held that fraud or knowledge on the part of the applicant as to his unsound condition of health was not material, the only question being whether the insured was **in fact**

in sound health at the time of the delivery of the policy. The reason that the cases were submitted to the jury was because there was conflicting evidence as to the soundness of the applicant's health at the date of delivery.

In our case, there is no dispute in the evidence as to the medical treatment of Mr. Miller between the date of the application and the date of delivery. It was stipulated by parties. Consequently, there was nothing to submit to a jury.

Plaintiff cites *Major Oil Corp. v. Equitable Life Assurance Society*, 457 F 2d 596. This case does not involve the contractual provision under consideration in the case at bar. Because of this, the Circuit Court of Appeals for the Tenth District did not find it necessary to discuss or comment on *Hurt v. New York Life Ins. Co.*, 51 F 2d 936, decided by the Circuit Court of Appeals of the Tenth District, which enforced a contractual provision almost identical to that involved in the case at bar. Furthermore, the evidence in the *Major Oil* case showed that the insurance company knew of, or had reason to know of, the physical condition and treatment of the applicant. In our case Miller and the plaintiff did not disclose the intervening medical treatment to the defendant and it is stipulated that the defendant *did not know of such treatment.*

Plaintiff, at pages 7 and 8, cites a number of cases from states other than Ohio. Many of these cases involve defenses of fraud in the applications. *Subar* shows that they are not applicable. Several of the cases involve sound health clauses as given in effect in those states. The *Howle* cases (supra), decided by the Supreme Court of Ohio, show that lack of knowledge of the insured with respect to his condition of health is of no significance.

While defendant insists that, under the Federal authorities and the Ohio authorities, the fact of treatment controls rather than the knowledge of the insured, we cannot refrain from pointing out the following:

Miller, president of the applicant, knew he had spent four days in the hospital under constant treatment by Dr. Ballou in October after the application was made and before the policy was delivered. He disclosed this knowledge to his own doctor one and one-half hours after the policy was delivered. It was stipulated that he did not tell the defendant anything about that medical treatment or hospitalization. It is absurd for the plaintiff to claim that it did not know of the medical treatment and hospitalization.

The Supreme Court of the United States has clearly stated in *Stipcich v. Metropolitan Life Ins. Co.*, 277 US 311, 72 LE 895 (1927) that an applicant for insurance who discovers a change in his physical condition seriously affecting his health and rendering statements in his application no longer true is under a duty to the insurer fully to disclose the facts and his failure to do so will constitute a defense on an action on the policy.

While no contractual provision was involved in *Stipcich*, the law as announced in *Stipcich* certainly supports the rationale of the many federal cases enforcing the contractual provision involved in our case. It will also be noted in *Stipcich* that Stipcich suffered a *recurrence* of a duodenal ulcer after applying for insurance before the delivery of the policy. This shows that the knowledge of the defendant that Miller had for many years had hypertension does not detract from the controlling significance of his medical treatment and hospitalization between the date of the application and the delivery of the policy.

CONCLUSION

There is no reason for this Court to reconsider questions of the type involved in the case at bar. There is no conflict in the Federal authorities or in the Ohio authorities. The principles applied by the lower courts are well established and require no further consideration. It is, therefore, submitted that plaintiff's petition for a writ of certiorari be denied.

Respectfully submitted,
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AFFIDAVIT OF SERVICE

STATE OF OHIO)
FRANKLIN COUNTY) SS.

The undersigned, Herbert R. Brown, attorney for Respondent, John Hancock Mutual Life Insurance Company, states that he has on the 3rd day of April, 1974, served by mail three printed copies of the foregoing Brief for Respondent in Opposition to the Petition for Certiorari to the United States Court of Appeals, Sixth Circuit, on Mr. Jack R. Alton, of Lane, Alton & Horst, 150 East Broad Street, Columbus, Ohio 43215, attorney for Petitioner, Atkinson-Dauksch Agencies, Inc., being all parties required to be served.

Herbert R. Brown

Sworn and subscribed to before me this 3rd day of April, 1974.

Dorothy D. Eye Notary Public
Franklin County, Ohio
Comm. Exp. 8-1-77